BAY AREA

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HEALTH LIBERATION NEWS

MEDICAL COMMITTEE FOR HUMAN RIGHTS
BAY AREA CHAPTER
P.O. BOX 7677
SAN FRANCISCO, CA. 94119

BAY AREA MCHR PLANS NEW DIRECTIONS

What are we doing? What are our goals? How do we get there?

These are the questions the steering committee of the Bay Area Chapter has been studying in search for meaningful organizational direction.

From its origins in the civil rights movement of the '60s, MCHR has acted in response to the need for fundamental change in the United States. It has provided medical presence in demonstrations and strikes. It has supplied volunteer nurses, doctors and technicians for free clinics. It has exposed the subhuman medical situation in prisons and fought for prisoners' rights to adequate care. It has joined in community demands for improvements in services rendered by public hospitals. It has criticized and presented alternatives to local, state and national reforms in the health field.

Though each of these activities has great value, together they add up to a hodgepodge of commitments, with MCHR members working in unrelated and uncoordinated efforts. This ad hoc way of life bears no relationship to an organized program directed at defined goals.

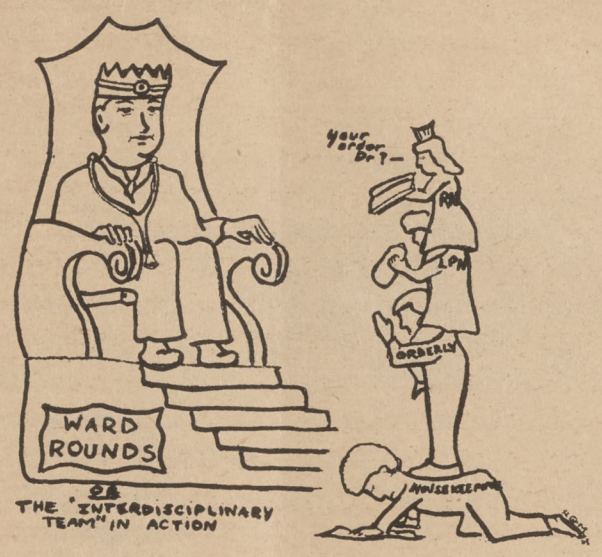
The steering committee feels that MCHR's main role should be to improve patient care and working conditions in health care institutions—hospitals, medical centers, health science schools. Why does Bay Area MCHR choose to focus on institutions? Most health personnel and students are in institutions, most of the money spent on health goes to these institutions, and more and more health care is delivered at institutions. For these reasons, institutional organizing should be MCHR's first priority.

In order to start our work, we must discuss with our co-workers what the major issues common to health institutions are. We sense that some of these issues are: adequate staffing, full utilizations of skills, job mobility and career ladders, on-the-job employee health, on-the-job workers meetings, job security, racism, sexism, participation in policy-making, in service training, childcare centers, and optimum equipment and facilities to deliver quality care. Without adequate working conditions in these areas, both employees and patients of any institution will suffer.

The steering committee will attempt to review actions in hospitals that have taken place to improve patient care and working conditions. Hopefully, we can find out what has succeeded, what has failed and how to produce more successes. We also encourage MCHR members to form study groups to learn who controls the health care system and how that control is exercised. Understanding the politics of health in one's institution is essential for changing the institution.

Institutional organizing projects, and other projects that MCHR members wish to undertake, should be presented in a written proposal for approval by the steering committee. Each project will be evaluated in terms of MCHR's principles and goals, which have been written down in MCHR documents of the past few years, and which will be clarified as projects take shape. Each project will choose a member to serve on the chapter's steering committee. Educational meetings will be held each month to discuss the projects.

The steering committee apologizes that it has not been very responsive to the needs and requests of people wishing to join and become active in MCHR. However, we felt that we ourselves must become clearer on our organizational directions before actively welcoming new members. We hope that projects will shortly begin to move forward and that new people will get in touch with us.



"HEALTH WORKERS"

We have been trying to find a term to describe ourselves and our co-workers in health institutions. We don't like to use the words "professional" or "technician" since such words set up false hierarchical divisions among people. The terms "employees" and "personnel" are dehumanizing; they make us part of an impersonal machine. The word "manpower" is unacceptable since 70% of people working in the health field are women.

So we have chosen to call ourselves and others engaged in health work "health workers." Health workers includes nurses, doctors, aides, orderlies, pharmacists, lab and X-ray technicians, medics, community health aides, and everyone who works to improve people's health.

NURSES BEWARE!

Written and edited by nurses

In July of this year the State Department of California, Budget Division published a plan titled "Nurses and California; An Overview of the Past and Present, and Projections for the Future."

The stated purpose of this report was to examine the output of nursing education in public higher education in this state, and to "question the need to change these programs in the future."

Confusing and contradictory statements throughout the 93 pages of this report make it difficult to read and its conclusions and proposals unrelated to its stated goals. However a careful reading of it shows that it is one more attack on the changes of a comprehensive health care delivery system being developed.

The recommendation that future educational programs plan to meet *employer needs* reinforces the profit oriented health delivery system that we now have, rather than seriously considering the needs of the community.

RNs', LVNs', ordelies'—all health workers'—considerations are attacked throughout the report. Proposed wage cuts are hidden within vague terms like "for budgetary consideration." In the appendix is proposed a 50% cut in LVNs and RNs at a saving to the state of almost two million dollars—again without consideration of the needs of the community, let alone the employment concerns of already existing nurses and people who wish to become same. Nurses are pitted against each other in the recommendation for two LVNs to be used instead of an RN, and two aids instead of one LVN,—again to save money.

Very rarely in the report are the questions of community input, upward mobility for nurses and the fragmented, costly, inadequate quality of our health care system raised. Even when these considerations are brought up however, they are not followed up by recommendations dealing with possible solutions,—*unlike* the budgetary concerns!

A basic problem with the whole report is that it was written by the same kind of people who are responsible for our current problems—legislators, administrators, and "toplevel" providers, and not by health workers and community people—the ones most affected potentially by this report.

Nurses Beware, (cont. from p.1), A Comparative Analysis

State's Proposals	A Nurse Comments	MCHR Proposals
p.i Preface states ". . . Misallocation of the state resources is not limited to dollars. It can include the state's most valuable resources, human skills, intellect, and drive."	Recommended solution? Using the same industrial and academic planners for future health care planning who have misallocated these resources.	Health care funds should be allocated by community health centers controlled by elected representatives of consumers and health personnel, who know the health care needs and who can be removed for failing to meet them.
p. ii warns of a future collision between nurses seeking jobs and the number available. p. 50 of the same plan states "National programs such as medicare dictate an increase in the demand for mursing personnel of all categories."	If there is a greater demand for nurses on p. 50, why is there a warning against educating more nurses on p. 11? Do we need less skilled health services as patients wait many hours to be treated?	Planning for health personnel must be done by the communities that use health services to be relevant.
p.6 states "in 1900, 35% of all health workers were doctors, and in 1972 there are only 9%." and on p. 8 "Financial constraint of the cost of physician access has generated growth of substitutes . . . such as registered nurses . . . . As the cost of registered nurses rose . . . L.V.N.s were substituted . . . and as the cost of L.V.N.s rose, aides were substituted.	Can cost be the number one priority for providing health services? Do we need less doctors? Look at the facts: • 22.1 out of every 1000 babies born alive will die before they are one year old. • In 12 other countries a new-born baby has a better chance for life. • An average American can expect to live 5 years less than a Swede, and 1.5 years less than an East German. What do these two countries have in common? Salaried doctors and no wasted tax dollars for profit.	The number one priority should be prevention of disease. The most valuable resources, human skills, intellect, and drive can best be preserved by the above kind of community control. Upward mobility based on skills and experience of present health personnel, inservice training and academic education will promote constant improvement in the health care system.
p. 18 Admits that "community health centers could produce nurses who could provide 88% of all health care services that are needed in the community."	But excludes community health centers in planning and in the recommendations in the conclusion.	MCHR agrees that mechanisms should and could be set up to allow each community to train all the health workers it needs. This might mean that people would receive their training in the community where they live, and thus they would be very likely to remain and serve their community in the future.
p. 21 tells of the high number of nurses who leave the health field–33% of diploma and 40-60% of degree nurses.	Day care centers are not provided at health institutions. Since nurses are required to work evenings, nights and weekends, childcare is difficult to obtain and often they must leave jobs to care for their children. Also, why should nurses remain in a health delivery system when rewards and upward mobility are less than in other fields?	Day Care centers should be provided for all health workers. All health workers must be given the opportunity to develop skills and receive appropriate recognition for their work.
p. 21 also points out the loss of credits to students which occurs when they transfer from one health educational institution to another, at a tremendous cost of time and money to themselves and to health tax dollars.	This practice of the health educational institutions is based on the concern to meet prestigious needs which have no relevance to the concerns of the communities they are supposed to serve.	All health education would be planned for by communities to meet their needs and students would transfer to appropriate institutions as needed without loss of credit, or cost to the student or community.
p. 24 deals with geriatric hospitals' and institutions' difficulties in maintaining R.N.s and a stable staff, and analyses the reason for this as being "because it's unpleasant."	Geriatrics is the area most discriminated against in the health delivery system, a ghetto created by lack of funds, planning, and staff. It is controlled by providers concerned only with profits with little regulation for standards control. Working in most of these institutions means accepting the malpractice of the providers to label this area of human care as unpleasant is to continue to perpetuate lack of understanding and concern for the abuses of senior citizens' rights within the present health delivery system.	Senior citizens would have representation on community health councils and help plan for and regulate all health care services at the optimum care level needed. Levels of care will be dictated by health needs, not by providers for profit. Health personnel will have an input in planning, deciding upon adequate equipment, facilities, equitable wages, and opportunities for advancement.
p. 29 Quote "With orderlies and nurses aides one can assume the number of people who are highly motivated for medical education is highly unrelated and is instead . . . constrained by the number of people willing to accept demeaning labor at a relatively low wage"	This assumption of lack of motivation in mainly minority workers for medical education is RACIST. The further acceptance that orderlies and aides work must be demeaning and low paid promotes racism in the health delivery system.	There should be no medical ghettos in community health planning. All health workers should have equal opportunity for upward mobility and input into planning and delivery of health services. Orderlies and aides work should not be low paid or considered demeaning. All health workers should have decent pay.
p. 32 assumes that California will continue to receive favorable balances of skilled nurses who will migrate from other states.	A plan to use health personnel educated at the cost of other states to fill in California shortages.	National health standards for consumers and health personnel controlled by the communities they work in will prevent this fragmentation of the health delivery system.
p. 36 advocates the use of two L.V.N.s in place of an R.N., two aides in place of an L.V.N., to control the budget, even though there are legal constraints! p. 46 proposes that "items such as disposable sheets syringes, and other equipment . . . will substitute for aides and L.V.N.s."	This pitting of one group against the other, giving less skilled health care, illegally if profitably, endangers the health of the consumer and health personnel, and further fragments care. It is the kind of health service that produces the profit-oriented abuses homes for the aged practice.	Community Health care services will encourage the greatest skills to be developed by each health worker, to cure disease and hasten recovery. The saving of cost will be because of the quicker cure, and the savings will be used for needed health services, *not* profits. All health workers have a particular skill to offer patients. Nurses, technicians, doctors, pharmacists, dieticians, etc. should work together in teams on an equal basis in making decisions.

CONT. ON PAGE 3

DR FACES GRAND JURY

On September 26, Dr. Philip Craven and 10 other people were subpoenaed to come before a federal grand jury in San Francisco. Phil had been an intern at San Francisco General Hospital and a medical resident at U.C. Medical Center from 1969-71. He was head of the S.F. General interns' association and helped initiate important improvements in patient care at the hospital. Phil is now working as a Public Health Service physician in Puerto Rico.

When Phil came to San Francisco, neither he nor the other 10 witnesses knew why they had been subpoenaed. He did know, however, that if he declined to answer the federal prosecutor's questions he could be sentenced to up to 18 months in jail.

This was a rough decision for him to make, but when repeatedly questioned over the last few weeks, he *did* decline to answer, citing many constitutional rights as his reasons, and he *was* sentenced to jail for contempt of court!–without a trial!!

His current status is that he is out of jail pending U.S. Supreme Court decisions on two defense motions–First is bail pending appeal of the conviction, and a decision on this may be handed down ANY DAY NOW. If denied Phil goes to jail immediately. If granted, he is allowed to stay out of jail until the Court rules on whether the contempt sentence was constitutional or not. This is expected to take longer.

What are these federal grand juries that have the power to send people to jail without trial?

Since 1970 the Nixon Administration has held a series of federal grand jury investigations of individuals and groups working for change in this country. Some of these cases have received wide publicity: Daniel Ellsberg and the Pentagon Papers, Father Berrigan, Leslie Bacon and Angela Davis; others have been largely unnoticed. It has become clear that federal grand juries are becoming the cutting edge of Nixon's repression of dissenting Americans.

The grand jury is, from the government's point of view, a vastly superior instrument than either FBI investigations or old-style HUAC inquisitions. People can simply refuse to talk to FBI agents or to HUAC committees; thus their investigations dry up. The federal grand jury, on the other hand, is designed to force people to talk. The tactic is to subpoena a number of people and then to give them immunity. Immunity used to mean that a person could never be prosecuted about anything mentioned in his/her testimony. Today, the new "use" immunity simply protects witnesses from prosecution based on what the person says to the grand jury. Other evidence gathered by the government from independent people can still be used to prosecute the witness. Therefore the immunity does not really protect against self-incrimination.

Once the person is given immunity, he/she has to face the choice of answering all of the grand jury's questions or being jailed for contempt of court. The jail sentence runs for the term of the grand jury. (A maximum of 18 months, although after the person is released, the *next* grand jury can call him up, ask the same questions and throw him back if he refuses to answer!)

The decision on whether or not to testify is a tough one. Many people feel that since they know nothing about any specific illegal acts they can testify without harming anyone or themselves. Unfortunately, it's not so simple.

The Government usually asks very broad questions. Examples: "Tell us the names of all the people you attended any riots or demonstrations with, and tell us the content of any discussions with those people which took place at those events." "Tell us the names of all the people you lived with over the past two years." "Do you know (. . . a list of people . . .)? Tell us all the times you ever saw them, and relate the substance of all conversations with them." Thus the FBI fattens its files on who knows whom, who lived where, etc. It is often hard for witnesses to know which seemingly innocent piece of information can harm someone else.

There have been over a dozen of these grand juries so far. They are run by the recently built-up Internal Security Division of the Justice Dept. This division used to work in the old days as an adjunct to the House UnAmerican Activities Committee, and helps the FBI gather information for its files.

Grand juries are much more effective than HUAC style proceedings. HUAC's main weapon was public exposure. Once poeple learned not to be afraid of the hearings, and began taking affirmative actions against them–demonstrations, actions to make a mockery of the proceedings, etc–HUAC was killed, Grand juries of course have the power to jail people, without a trial, and use this pressure to make people talk.

Furthermore, the grand jury operates in secret. A witness is not even allowed to have a lawyer present, much less friends or the press! This secrecy also helps sow distrust, since only the witness knows what went on in the jury room.

Finally, grand juries can strike anywhere and at any time. Usually the witnesses are given only a few days notice, and often they are forced to appear far from their family and friends. (Phil was given a week's notice at his home in Puerto Rico to appear in San Francisco!)

We hope that the Supreme Court finally takes a stand against this blatant denial of our constitutional rights. Meanwhile, the Grand Jury Defense office of the National Lawyers Guild can provide general information about grand juries and specific help in time of need–they have contacts with lawyers all over the country. Contributions to help pay for the expenses around the defense of Phil and the others should be sent to them–2588 Mission St., Rm. 207, San Francisco, CA, 94110. (415) 285-9206)

BILLIONS FOR BAND-AIDS * * * $2 * * *

An analysis of the U.S. health care system and of proposals for its reform, BILLIONS FOR BAND-AIDS is a 127-page book of facts and information, published this fall by Bay Area MCHR. It details the power of the insurance industry and the drug monopoly. It dispels the illusion of patient well-being carring any weight in health maintenance organizations (HMOs) or in any of the proposals for national health insurance. It shows who pays and who profits from the health care bill. This product of research by a nurse, a health science student and a doctor is an indispensable source book for health workers and community groups working to change our health system.

Published by Bay Area MCHR, BILLIONS FOR BAND-AIDS is available @$2., with discounts for bulk orders. Use the form below to place your order. All orders must be prepaid. Please include 25 cents for postage and handling per copy.

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Bay Area Chapter MCHR - P.O. Box 7677
San Francisco, California 94119

Enclosed is $ for copies of BILLIONS FOR BAND-AIDS

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Copies may also be purchased in person at MCHR office – 558 Capp St., S. F. Telephone for bulk order rates: 824-5888.

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p. 35 states that "Individuals and the nation have limited ability to allocate resources for health care with respect to the kinds of manpower .... health care in general and nursing care in particular will continue to be a mixture of the ideal of the academic and the reality of the market place."

What does this really mean? If only ivory towered academics (who are completely ignorant of community health needs) and profit hungry providers continue to plan and control the health delivery system, it will continue to be fragmented and costly, and fail to meet the needs of most citizens.

The MCHR proposal does not permit control of planning and delivery of health care services by academic or industrial interests and profits.

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p. 47 states "There is obviously a trend to the extension of total health care as a right .... The degree to which this is implemented will influence to a considerable degree nursing services."

It should be more than obvious that health care is a right. The World Health Organization states that optimum health is a human right. This plan doesn't propose any consideration of that right in its conclusions. Proposals to cut personnel or substitute less skills defeats this goal.

MCHR proposal is based on the premise that promotion of good health is a human right. The promotion of health requires priorities for the prevention of disease and rehabilitation after disease has struck to return to optimum health.

AVAILABLE FROM MCHR

Speakers: MCHR members are available to speak to all kinds and sizes of groups on a variety of topics. The speakers come from many backgrounds—nurses, health science students, technicians, doctors, health activists. Below is a list of topics we can provide speakers for. If you are interested, call or write the office and we will try to provide the speaker best suited to talk to your group.

National Health Insurance
Women in Health
Nursing
Patients Rights and Advocacy
Paraprofessionals
Drug Industry
Health Maintenance Organizations
Community Organizing in the Haight Ashbury
Health in the Haight Ashbury
Mental Health in the Peoples Republic of China
Illustrated Lecture on Health Care Delivery
in China (Acupuncture, Herbal Medicine, etc.)
Drug Abuse
Methadone
Adolescence
Radical Mental Health
Prison Health
Medical Aid to Indochina
Vietnam and the Health Movement
Free Clinics
Alternative Therapy
MCHR—Its History and Future

Speakers on these topics will of course discuss them from MCHR's viewpoint. We would like to use this speakers bureau as a fundraising mechanism for the chapter, but this would be negotiated depending on the particular group's finances.

Films, etc.

Health War (sometimes called "Struggle for Life") An excellent 25-minute film on health in Vietnam. The first half documents the health problems caused by the war—bombs, napalm, anti-personnel weapons, CBW, etc. The second half described the health care system that the North Vietnamese and NLF have set up to deal with these problems, and includes an interview with the Minister of Health of the DRV, shots of an operation performed in a cave with a bicycle-powered generator, etc. (Black & White)

It happens to Us—A film on abortion—interviews with women who have had one, the procedures used, the psychological effects, all in the form of real life stories. Womens groups have found this film interesting, but not nearly as political as it should be. It should be used with a speaker. (Color)

NARMIC Slide show—Put out by the American Friends Service Committee in Philadelphia, this is a brutal description of exactly what the automated air war means and what it is doing to Indochina. Comes with a script numbered slide by slide so that anyone can give it. (Color)

China Slide show—Two members of our chapter went on an MCHR tour of China, and have prepared a slide show talk about medicine in China—They do the narration and are prepared to answer questions afterwards. (Color)

We have to charge a small processing fee for all films and slides, as they are being used a lot and need repair and cleaning.

Other Resources—

The Indochina Sub Committee of our chapter is putting together a list of additional resources—speakers, films, etc.—on the war. Call the office for further help on this. If you are interested in a speaker on a topic not listed, call and we will try to help you.

Literature: The office now has a large supply of various kinds of MCHR and health literature. Individual packets of a representative sampling or bulk orders are available. We print several thousand extra copies of our newsletter each month for bulk distribution in institutions, etc.—call if you are interested. Finally, we have available a number of books for sale. You can call or write for a complete list and price information.

MCHR CONTACTS
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Davis—Tom—756-8509
Sacramento—Mark—442-2819

HEALTH/PAC

The Health Policy Advisory Center (Health/PAC) has opened a west coast office in the same building as MCHR. Since its beginning in 1968 in New York City, the organization has exposed the inequities of the health system, and monitors new developments in health care reform. The new west coast staff, Elinor Blake, Tom Bodenheimer, and Judy Carnoy, is preparing articles for the *Health/PAC Bulletin* on political and economic developments currently effecting county hospitals, and on foundations for medical care. They are also anxious to work with community groups, health workers, and students.

The officy maintains news clippings files, past issues of the *Bulletin*, and additional books and pamphlets written by Health/PAC and other groups. Subscriptions to the *Bulletin* are $5 for students, $7 for others, and $15 for institutions. The organization is located at 558 Capp St., San Francisco 94110; the phone is 282-8696.

CALENDAR OF EVENTS OF INTEREST

Monday, Nov. 27, 7:30 p.m.—Vinceremos Brigade, organizers of work brigades to Cuba, is putting on *a slide show on Cuba, the last Brigade, and health slides for MCHR members.* (They are currently recruiting for the Brigade in March—Deadline for applications is Dec. 5th, so those interested should definitely come Monday night, and get in touch with the Brigade.) Show will be at 2519 Pacific Ave., San Francisco. *

Sunday, Dec. 3, 7:30 p.m.—*"Health Care Delivery in China"*—A talk and slide show given by two members of Bay Area MCHR, Fran Shapiro, R.N. and Phil Shapiro, M.D., who went on the MCHR tour to China this summer. Community Music Center Auditorium, 544 Capp St., San Francisco.

Friday, Dec. 8, 3 p.m.—*Same as above!!!* Theme House, Building T7, just north of the Campanile Tower on the UC Berkeley Campus. For East Bay people.

Saturday, Dec. 16—*Big Party—Pre-holidays and post finals!* Bring stuff to eat and drink—We are working on a women's band for it. Meet your fellow MCHR members. 1762 Page St., San Francisco. FLASH - "ISIS" WILL PLAY!!

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MCHR MEMBERSHIP

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☐ I would like to join MCHR.
Enclosed are dues of $_____.

☐ I am making a contribution of $
to MCHR.

☐ I pledge $_____ each month to MCHR,
beginning _____.

FAIR SHARE DUES SCHEDULE
(please check proper box)

INCOME	% OF INCOME	CONTRIBUTION
up to $5,000	.1%	$8 ____
up to $10,000	.2%	$10-20 ____
up to $15,000	.3%	$30-45 ____
up to $20,000	.4%	$60-80 ____
above $20,000	.5%	$100 up ____

☐ I would only like to subscribe to Health Liberation News. Here's $3.

☐ I would only like to subscribe to Health Rights News. Here's $5.

☐ I would like more information on MCHR's _____ project.

Dues and contributions are tax-exempt.